FEE FOR SERVICE HEALTH BENEFIT PLAN COMPARISON FORM

BENEFIT	FEE FOR SERVICE STANDARD PLAN	XXX PLAN
Deductible Maximum out of Pocket for Covered Expenses After Deductible Coinsurance Lifetime Maximum Benefit	Single $400 Family $800 Single $1500 Family $3000 As Indicated for Each Service Deductible Applies As Noted (*) Unlimited	
In-Hospital Care - Authorized In-patient Care, Semi Private Room and Misc. Services, Intensive/Cardiac/Neonatal Care Ancillary Services, Preadmission Testing	15% Coinsurance*	
Transplant (Kidney, Cornea, Bone Marrow, Heart, Liver, Lung, Heart/Lung, Pancreas, Small Bowel	15% Coinsurance*	
Out-Patient Services - Provider Office Visit, Office Diagnostic & Allergy Testing, Ambulatory/Hospital Outpatient Surgery, Allergy Serum and Injections, Diabetes Education, Therapy, Radiation, Chemotherapy, and Dialysis	20% Coinsurance*	
Diagnostic Testing	20% Coinsurance	
Maternity Care - Prenatal, Labor, Delivery and Postpartum	15% Coinsurance* Dependent Pregnancy Covered	
Emergency Services - Hospital Emergency Room (Coinsurance Waived if Admitted), Ground Only Ambulance	20% Coinsurance*	
Preventive Services: Immunizations Well Child Care - Age and Periodicity Limits May Apply Well Adult Care - Age and Periodicity Limits May Apply	10% Coinsurance Per Plan Year Ages 0-3 Office Visits Covered to $200 - Ages 4-18 Office Visits Covered to $100 - No Coinsurance - No Coverage Above Limit Per Plan Year $300 for Routine Physical Exam and Specified Testing No Coinsurance or Coverage Above Limit	
Mental Health Inpatient (Day Treatment/Intensive Outpatient Can Be Substituted for Inpatient Days on a 2:1 Basis) Outpatient Autism (Ages 2 through 21) $500 Monthly Benefit (Therapeutic, Respite, and Rehabilitative Care)	20% Coinsurance, 21 days/Plan Year, 1 admission/6 months* 20% Coinsurance, 20 visits per Plan Year* Coinsurance Applicable to Service Provided*	
Substance Abuse	Same Benefit Level as Mental Health	
Prescription Drugs and Contraceptives	20% Coinsurance - 1 month supply*	
Physical/Occupational/Cardiac Rehabilitation Therapy	20% Coinsurance 26 Weeks/Plan Year*	
Speech Therapy	20% Coinsurance 26 Weeks/Plan Year*	
Home Health Care	100 Visits/Plan Year Covered in Full	
Skilled Nursing Facility	20% Coinsurance 28 Days/Plan Year*	
DME/Prosthetics/Hearing Aids	20% Coinsurance*	
Hospice	Medicare Benefit*	
Additional Rows as needed for Supplemental Benefit Riders		
MONTHLY PREMIUM	**$**	**$**

Benefit Reductions Or Denials Can Result From Failure To Follow The Plan's Rules
Ask What Restrictions Apply!
Benefits and Exclusions Are Subject To Modification Upon Renewal

(2002 Edition)